NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 18, 2003

RE: MDR Tracking #: M2-03-1355-01-ss
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

Claimant suffers chronic low back pain from alleged work compensable injury on ___.

Requested Service(s)

Percutaneous lumbar disc decompression at L3-4 and L4-5.

Decision

I agree with the insurance carrier that the in question intervention is not medically necessary.

Rationale/Basis for Decision

A diagnosis of radiculopathy has been made and documentation of abnormal neurologic exam is noted in the records. However, there is no objective support with EMG/NCV studies for this diagnosis. MRI report dated 4/11/03 documents no herniation, neural compression or stenosis identified. Discography report of 5/01/03 does not document a control level. There is concordant pain and radiation at all levels tested.

Specifically at L5-6, concordant pain and radiation, 8 on a scale of 10; at L4-5, 8 on a scale of 10; at L3-4, 6 on a scale of 10; and at L2-3, concordant pain and radiation, 2 on a scale of 10. There is no place for disc decompression in light of no evidence of disc herniation, neural compression or stenosis, and no documentation by EMG nerve conduction study of significant radicular condition.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

This decision by the IRO is deemed to be a TWCC decision and order.